Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: June 28, 2024

Inspection Number: 2024-1100-0003

Inspection Type:
Critical Incident

Licensee: Rykka Care Centres LP

Long Term Care Home and City: Hawthorne Place Care Centre, North York

Lead Inspector	**Inspector Digital Signature**
Ryan Randhawa (741073)	Ryan Randhawa Digitally signed by Ryan Randhawa Date: 2024.07.03 12:06:06 -04'00'

Additional Inspector(s)
Cindy Ma (000711)
Amal Ahmed (000819) was present during this inspection

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 27-31, 2024 and June 3-7, 11, 12, 2024

The following intake(s) were inspected in this Critical Intake (CI) inspection:

- Intake: #00111742 - [CI: 2586-000031-24] - was related to medication management
- Intake: #00112115 - [CI: 2586-000035-24] - was related to abuse
- Intake: #00112716 - [CI: 2586-000037-24] - was related to abuse
- Intake: #00113600 - [CI: 2586-000039-24] - was related to neglect
- Intake: #00113632 - [CI: 2586-000040-24] - was related to abuse
- Intake: #00114487 - [CI: 2586-000043-24] - was related to abuse
- Intake: #00115015 - [CI: 2586-000045-24] - was related to falls

- Intake: #00115264 - [CI: 2586-000047-24] - was related to outbreaks
- Intake: #00115449 - [CI: 2586-000048-24] - was related to abuse

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Medication Management
Infection Prevention and Control
Responsive Behaviours
Prevention of Abuse and Neglect
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident as specified in the plan related to specific personal care.

Rationale and Summary

A resident's plan of care indicated that staff were to provide the resident a certain level of assistance for an activity of daily living (ADL).

Record reviews indicated that on a day in April 2024, a Personal Support Worker (PSW) provided the incorrect level of assistance for the ADL. This was also verified by the PSW.

A Nurse Clinician and Director of Care (DOC) confirmed that the PSW failed to follow the resident's plan of care when they provided the incorrect level of assistance for the ADL.

Failing to follow the plan of care put the resident at risk for potential harm.

Sources: Resident's clinical records; home's investigation notes; and interviews with PSW, Nurse Clinician and DOC.
[000711]

COMPLIANCE ORDER CO #001 Duty to protect

NC #002 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 24 (1)
Duty to protect
s. 24 (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The inspector is ordering the licensee to comply with a Compliance Order

[FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:

1. Conduct audits daily for a period of two weeks following service of this order to ensure that resident #002's specified intervention is being completed and kept away from resident #003's room.
2. Conduct audits daily for a period of two weeks following service of this order to ensure that resident 003's specified intervention is completed by ensuring that resident #002 and/or other co-residents do not enter resident #003's room.
3. Conduct audits daily for a period of two weeks following service of this order to ensure that resident #007's specified responsive behaviour intervention is completed as identified in their care plan.
4. Maintain a documented record of the audits conducted in step 1, 2, 3 to include, but not limited to: dates of audit completion, the staff member who conducted the audit, residents audited, results of each audit and corrective actions taken in response to the audit.

Grounds
The licensee has failed to ensure that resident #003 was protected from physical abuse by resident #002, resident #006 was protected from physical abuse by resident #007, and resident #005 was protected from physical abuse by resident #006.

Ontario Regulation (O. Reg.) 246/22 s. 2 (1), defines "physical abuse" as the use of physical force by a resident that causes physical injury to another resident.

Rationale and Summary

i) An altercation occurred between resident #003 and resident #002. Resident

#003 attempted to hit resident #002 and resident #002 retaliated and hit resident #003. As a result of the altercation, resident #003 sustained injuries. This was also confirmed by a RPN who witnessed the above interaction between residents #002 and #003.

A Nurse Clinician and DOC verified the above mentioned incident constituted as physical abuse.

There was physical impact to resident #003 when they were physically abused by resident #002.

Sources: Critical incident report #2586-000048-24; residents' clinical records; and interviews with RPN, Nurse Clinician and DOC.
[000711]

ii) An altercation occurred between resident #006 and resident #007 when they were holding onto each other. As a result, resident #006 sustained an injury.

A PSW indicated that resident #007 holding onto resident #006 caused the injury to resident #006. The PSW, Behavioural Support Lead (BSO Lead), a Nurse Clinician, and DOC acknowledged that resident #007 used physical force and caused injury to resident #006 and that this constituted as physical abuse.

Failure to protect resident #006 from physical abuse by resident #007 led to resident #006 sustaining a physical injury.

Sources: Resident #006 and resident #007's clinical records; CI # 2586-000035-24; home's policy "Abuse and Neglect, RCS P-10," review date Feb 3, 2023; interviews with PSW, BSO Lead, Nurse Clinician, DOC and other staff.

[741073]

iii) An altercation occurred between resident #006 and resident #005 when resident #006 grabbed resident #005 resulting in an injury to resident #005.

Resident #005 indicated that resident #006 grabbed them and caused the injury. A PSW, BSO Lead, a Nurse Clinician, and DOC acknowledged that resident #006 used physical force and caused injury to resident #005 and that this constituted as physical abuse.

Failure to protect resident #005 from physical abuse by resident #006 led to resident #005 sustaining a physical injury.

Sources: Resident #005 and resident #006's clinical records; CI # 2586-000043-24; investigation notes; home's policy "Abuse and Neglect, RCS P-10," review date Feb 3, 2023; interviews with resident #005, PSW, BSO Lead, Nurse Clinician, DOC and other staff.
[741073]

This order must be complied with by August 2, 2024

An Administrative Monetary Penalty (AMP) is being issued on this compliance order AMP #001

NOTICE OF ADMINISTRATIVE MONETARY PENALTY (AMP)

The Licensee has failed to comply with FLTCA, 2021

Notice of Administrative Monetary Penalty AMP #001
Related to Compliance Order CO #001

Pursuant to section 158 of the Fixing Long-Term Care Act, 2021, the licensee is required to pay an administrative penalty of $11000.00, to be paid within 30 days from the date of the invoice.
In accordance with s. 349 (6) and (7) of O. Reg. 246/22, this administrative penalty is being issued for the licensee's failure to comply with a requirement, resulting in an order under s. 155 of the Act and during the three years immediately before the date the order under s. 155 was issued, the licensee failed to comply with the same requirement.

Compliance History:

CO #001 FLTCA, 2021, s. 24 (1) under inspection #2023_1100_0008 issued December, 18, 2023.
CO #001 FLTCA, 2021, s. 24 (1) under inspection #2023_1100_0005 issued April, 3, 2023.

This is the second AMP that has been issued to the licensee for failing to comply with this requirement.

Invoice with payment information will be provided under a separate mailing after service of this notice.
Licensees must not pay an AMP from a resident-care funding envelope provided by the Ministry [i.e., Nursing and Personal Care (NPC); Program and Support Services

(PSS); and Raw Food (RF)]. By submitting a payment to the Minister of Finance, the licensee is attesting to using funds outside a resident-care funding envelope to pay the AMP.

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.